pureau o	i Licensule and Ce	THILLAHOTT					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIE A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
<u> </u>		NVS5002AGC				12/1	1/2008
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
HOLY FA	MILY ADULT CARE	HOME LLC		NEYPEAK A NS, NV 8910			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000			
:	This Statement of Deficiencies was generated as a result of the annual state licensure survey and complaint investigation conducted at your facility on 12/11/08.  The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the			Acceptable 5/5/ 38e	POC 109 rezerka		
Nevada State Board of Health on July 14, 2006  The facility was licensed for 6 total beds.  The facility had the following category of classified beds: Category 2 - 6 beds		. 1					
		f					
	Residential facility	e following endorsem which provides care ersons, and/or person	to elderly				
	Three resident file	time of the survey was and two discharged d and 6 employee file	l resident 🏻				
	There were 2 complaint(s) investigated during the survey.  Complaint #NV00018552 Unsubstantiated  Complaint #NV00019500 Unsubstantiated						
	by the Health Division prohibiting any crimactions or other clause available to any pastate, or local laws		strued as ations, ay be federal,		MAY	EIVED 0 4 2009 SURE AND CERTIFICATION EGAS, NEVADA	
	The following regulidentified:	ulatory deficiencies w	ere				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Licensure and Ce	Tuncauon		<del></del>		T		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	NVS5002AGC		B. WING _		12/11	/2008	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE			
			NEYPEAK A S, NV 8910				
PRECIV (EACH DEFICIENC	ATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
Provide oversimembers of the sto ensure that rest and protective sure in compliance with the state of th		he ecessary d services facility is NAC	Y 050	DEGULATION TO BUT A TOUR TO BU	000 000 000 000 000 000 000 000 000 00	10 4 me	
Based on observer review the admin oversight and directly staff of the facility residents receive supervision and to compliance with 449.156 to 449.2 of NRS.  Findings include:  Please refer to T. #Y661, #Y662, #	is not met as evidence ation, interview and resistrator failed to providention for the member as necessary to ensure needed services and hat the facility was in the requirements of N 766, inclusive, and character as \$\frac{4}{2}\$ (\$\frac{4}{2}\$) (\$	ecord de rs of the ure that protective AC eapter 449		d) 20 mm, 572200 monitor 25 21 monids 2 661, #662, 4 15 meet. 2) 4/28/09 8) 27 red mant 27 x 20d mant 27 x 20d mant	000 TOG 1001, 4 900 1000 1000 1000 1000 1000 1000 100	1000 1000 11000 11000 11000	
Y 051 449.194(2) Admi Responsibilities-			Y 051		_		

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If continuation sheet 2 of 58

Bureau of Licensure and Certification (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES ID. (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 051 4054 Y 051 Continued From page 2 a) STOFF OF THE FACILITY Hos insormed keaduring NAC 449.194 The administrator of a residential Leaveston of MACHUANIA facility shall: (b) 60ministre00012 Dasia. Designate one or more employees to be in charge of the facility during those times when the MATE Employee in emplis administrator is absent. Except as otherwise IN THE BUSENCE OF SHE provided in this subsection, employees 00mm15720002. designated to be in charge of the facility when the administrator is absent must have access to all d) soministantor well areas of and records kept at the facility. mon son Foculty was Confidential information may be removed from Desiculted employer the files to which the employees in charge of the facility have access if the confidential information in estource of reforme is maintained by the administrator. The d) the their the ADS WALL administrator or an employee who is designated to be in charge of the facility pursuant to this emprense in exoruce subsection shall be present at the facility at all ATT BELL MENT AL times. The name of the employee in charge of the facility pursuant to this subsection must be e) 4/25/09 posted in a public place within the facility during 8) em Droyae #4+#5146 485 all times that the employee is in charge. TOULMIN STERN) 15 OF 1/1/09. This Regulation is not met as evidenced by: 9) EMPLOYER #2+ #3 WEYER Based on observation, interview and record review, the administrator failed to designate one Tackminister yelevnesacias or more employees to be in charge of the facility DE EDUCALINERA. when the administrator was absent. Findings include: There was no documented evidence of an employee designated to be in charge in the absence of the administrator.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Employee #4 was hired on 9/2/08. The employee was not aware of who would be in charge in the absence of the administrator. The employee notified the owner of the facility (Employee #2) by

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12/11/2008

## Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING
		A. BUILDING

(X3) DATE SURVEY

NVS5002AGC

B. WING\_

COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## HOLY FAMILY ADULT CARE HOME LLC

1013 STONEYPEAK AVE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)
Y 051	Continued From page 3 phone during the survey. The owner relayed to Employee #4 she could answer any questions.  Employee #4 left a message for the administrator (Employee#1) to notify him of the survey taking place in the facility. The administrator had not returned the phone call during the survey.	Y 051	VOS3  (a) GTAFF OF TEST FACTURY  HOS INTOLINED RECEDENCE  WHE WEELDLATION OF NAC  AUG. 1944  (b) ADMINISTRATOR WELL
Y 053	Severity: 2 Scope: 3  449.194(4) Administrator's Responsibilities-Complete Rec	Y 053	18 in comprimer winds NAC 149,194 LEQUESTIONS ON \$ 070, 4100, 4101, 4103
-	NAC 449.194 The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate.		VIDA, VIOS, VIDG. FOR STOTA  C) DOMINISTRAÇÃO ULLIL  ENQUER THOT FOCILITAI  15.17 COM PLIMAR ACTUA  NAC 449.194 REGULATION  ON VIUS, V859, V933
	This Regulation is not met as evidenced by: Based on record review, observation and interview, the administrator failed to keep complete and accurate records.		1936 FOU VEG. DE 275 PERUS DINON PLLES.  d) 4/78/09
	Findings include:  Please refer to Tags #Y070, #Y100, #Y101, #Y102, #Y103, #Y104, #Y105, #Y106, #Y645, #Y859, #Y933 and #Y936.		
Y 067	Severity: 2 Scope: 3  449.196(1)(c) Qualifications of Caregiver- Read regulation	Y 067	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 4 of 58



STATEMENT	OF	DEFICI	ENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE C	ONSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS5002AGC

B. WING

12/11/2008

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER  HOLY FAMILY ADULT CARE HOME LLC	STREET ADDRESS, CITY  1013 STONEYPEAK  LAS VEGAS, NV 89	AVE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 067 Continued From page 4  NAC 449.196  1. A caregiver of a residential facility must: (c) Understand the provisions of NAC 449.156 to 449.2766, inclusive, and sign a statement that he has read those provisions.	Y 067	4067  (a) STATE OF THE FOCK  HE INFORMAND RACE  REGIONATION OF N  (ALL  b) DOMINISTRATOR  INDUITOR THAT NACE  CONTRACTOR BY THE  EMPLOYEE OF THE	400mg
This Regulation is not met as evidence Based on personnel file review the facil ensure 6 of 6 employees had read and understood the provisions of NAC 449.2766.	lity did not	stand on the state of	onjace
Findings include:  Employee #1 had an unknown date of hemployees file did not contain a signed indicating the employee had read and uthe regulations for Residential Facilities Groups.	statement understood	elempicale da	5 , # 6
Employee #2 had an unknown date of the There was no documented evidence of statement indicating the employee had understood the regulations for Residen Facilities for Groups. There was no ento review.	f a signed read and itial	- new Escreament at	e to take
Employee #3 had an unknown date of There was no documented evidence of statement indicating the employee had understood the regulations for Residen Facilities for Groups. There was no ento review.  If deficiencies are cited, an approved plan of correction must be	f a signed read and itial nployee file	8) A 28/09  8) SOMINICADATOR  MONITOR EMPLOY  CERCELLIST ST L  ELEVER SIX MONITOR	12 2 10 10 10 10 10 10 10 10 10 10 10 10 10

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STATEMENT OF DEFICIENCIES	C
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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A. BUILDING	

(X3) DATE SURVEY COMPLETED

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B. WING

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 1013 STONEYPEAK AVE

HOLY FA		ONEYPEAK A SAS, NV 891	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
Y 067	Continued From page 5	Y 067	NAC HAG. 196 15 mest
	Employee #4 was hired on 9/2/08. There was no documented evidence of a signed statement indicating the employee had read and understood the regulations for Residential Facilities for Groups. There was no employee file to review.		Big years Fooder tel
	Employee #5 was hired on 9/2/08. There was no documented evidence of a signed statement indicating the employee had read and understood the regulations for Residential Facilities for Groups. There was no employee file to review.	1	
	Employee #6 had an unknown date of hire. There was no documented evidence of a signed statement indicating the employee had read and understood the regulations for Residential Facilities for Groups. There was no employee file to review.	;	1070  Q) STOFF OF THE FOCULTY  HOS INFORMAD REBOUTING  THE RECULATION OF MAC
	Severity: 1 Scope: 3		A49,196(1)(7),
Y 070	449.196(1)(f) Qualifications of Caregiver-8 hours training	Y 070	b) ADMINISTRATOR LILLE MONITOR TELOT FACILITY 15 IN COMPERANCE CRITE
	NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.		MAC MAGINATON CONTRACTOR  CONTRACTOR STUBTON MECH  MONITON TON TON CONTRACTOR  CHARCICINST OT LONDS
	This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure 4 of 6 caregivers received eight hours of annual training (Employee #1, #2, #3, and #6).		Eucour esseis Employes is in compulance unit
	Employee #1 had an unknown date of hire. There was no documented evidence of 8 hours o training received in the past 12 months.		d) en pore e d

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Licensure and C	Certification					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION N			(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
	NVS5002AGC		B. WING _	<u>.</u>	12/1	1/2008
NAME OF PROVIDER OR SUPPLIE	R	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
HOLY FAMILY ADULT CAR		NEYPEAK A AS, NV 891				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 070 Continued From	page 6		Y 070			
	left with the administra inistrator did not return the survey.					
There was no en #2 was the owne	d an unknown date of had an unknown date of had a review. Ear of the facility. The ended answer are	Employee nployee				
	d an unknown date of h nployee file to review.	nire.				
	d an unknown date of h oployee file to review.	nire.				
	s unable to explain why e files in the facility.	y there				
Severity: 2	Scope: 3					
Y 072 449.196(3) Quali re-training	cations of Caregiver-M	led	Y 072	4072 @\STAFF OF R	102 74C	Lirey
facility in the admincluding, withou medication or die must: (a) Receive, in a pursuant to NRS	assists a resident of a rainistration of any medit limitation, an over-the stary supplement, the oddition to the training re 449.037, at least 3 horagement of medication	cation, -counter aregiver equired urs of		188 10000000000000000000000000000000000	(3) 280 2000 2000 6(3) 15	10000000 101 70 101 65

caregiver must receive the training at least every

3 years and provide the residential facility with satisfactory evidence of the content of the training

(b) At least every 3 years, pass an examination relating to the management of medication

and his attendance at the training; and

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FACILITY US IN CONPULA

Rureau	of Licensure and Ce	rtification			$\bigcirc$		: 01/15/2009 APPROVED
Bureau of Licensure and Certification  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  NVS5002AGC			(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION  G	(X3) DATE SI COMPLE		
NAME OF PROVIDER OR SUPPLIER  1013 ST		1013 STC	DRESS, CITY, S DNEYPEAK A AS, NV 8916				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 072	Continued From pa approved by the Bu			Y 072	to compendents  Leaveston  d) employees	VE-TU	of Dining
This Regulation is not met as evidenced by Based on interview and record review, the failed to ensure 1 of 6 caregivers had compute the required medication management traini (Employee #4).  Findings include:		he facility ompleted		and mary	em Plo		
	documented evide management traini she had not taken employee indicated initials on the Medi	hired on 9/2/08. Ther nce of medication ng. The employee in the course at this timed she was placing the cation Administration d the medication cour	dicated e. The owners Record				
V 088	Severity: 2 3 4493199(4) Staffin	Scope: 3		Y 088	4.05.97		
1 000	NAC 449.199 4. The administrate maintain monthly a the number and tyling the facility assigner must be amended	or of a residential faci written schedule that oe of members of the d for each shift. The if any changes are m	t includes staff of schedule ade to the		1088  Q) 55877 GX.  4.86 INTOL.  124 CULATU  199 (4).	MED OF	S. C. SELDINK, VI DC 21419.

monthly staffing schedule for at least six months. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

schedule. The schedule must be retained for at

least 6 months after the schedule expires.

This Regulation is not met as evidenced by:

Based on observation and interview, the administrator failed to maintain and retain a

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STATEMENT OF DEFICIENCIES	(X1)	PF
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	

(X3) DATE SURVEY
COMPLETED

NVS5002AGC

A. BUILDING	
B. WING	

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FAMILY ADULT CARE HOME LLC	1013 STONEY LAS VEGAS, I	PEAK A	WE
(X4) ID SUMMARY STATEMENT OF DEFICIENCY PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETE  DATE
Y 088 Continued From page 8	Y	088	and were the ported travel
Findings include:			and year on fill foll
There was no documented evidence o schedule in the facility.	of a staff		2000000. d) 25+4 cesmons & 8,7+6,4088
Employee #4 was hired on 9/2/08. The indicated there was no staffing schedu Employee #4 and Employee #5 reside facility and worked all the time. The errevealed there was another employee to the facility on Sundays from 10:00 APM.	ile. d at the mployee who came		2) 4/28/09
Severity: 1 Scope: 3			Y100
Y 100 449.200(1)(a) Personnel File - Employ	/ee Info Y	100	ress informed vectorions
NAC 449.200  1. Except as otherwise provided in sultance a separate personnel file must be kep member of the staff of a facility and m (a) The name, address, telephone nur social security number of the employe	t for each oust include: mber and		D) ADMINISTERIOR LELLE  MONITOR TOLORER LELLE  15 IN COMPLIANCE LELLE  NACILLE. 200(1)(a) Macic  Lanon.  C) ADMINISTRATOR WAS
This Regulation is not met as evidence Based on personnel file review and in facility failed to provide an employee f residents (Employee #2, #3, #4, #5 ar	terview, the lile for 5 of 6		SECT OF AN INDIVIOUSC PORCESONAL FLE FOR THE DR COUDE TO BE
Findings include:			firms para socia con
Employee #2 did not have an employer review.	ee file to		d) sommertous reces
Employee #3 did not have an employe f deficiencies are cited, an approved plan of correction must	ee file to		Emproyees sausonal

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies

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Bureau of Licensure and Cer	<u>rtification</u>		<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
	NVS5002AGC		B. WING	12/11/2008
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE, ZIP CODE	
HOLY FAMILY ADULT CARE	HOME LLC		EYPEAK AVE	

HOLY FA		13 STONEYPEAK A AS VEGAS, NV 891		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 100	Continued From page 9	Y 100	* TUES OF LANGE (3000)	C1 501X
	review.		Factorials in con	
	Employee #4 did not have an employee file review.	to	reallyrons.	
	Employee #5 did not have an employee file review.	to	2) 4/28/09	
	Employee #6 did not have an employee file review.	to		
	Employee #4 provided a copy of her cardiopulmonary resuscitation (CPR) certificand her resume from her personal records.			
	Employee #5 provided a copy of his resume his personal records.	e from	4101 (4) STOFF OF WAR FOCI	
	Employee #4 indicated she was not aware where the employee files were kept in the facility office and did not know he locate the files.	acility. oyee	() AC 2149. 200 (1) (1) LOTIONS. (1) AD MINISTRATOR. MONITOR PACILITY	veaco.
	Severity: 2 Scope: 3		SOME FILE MOS	MAC. siz
Y 101	449.200(1)(b) Personnel File - date of hire	Y 101	200(1)(b) Reacher	uneur
	NAC 449.200  1. Except as otherwise provided in subsect a separate personnel file must be kept for emember of the staff of a facility and must in (b) The date on which the employee began employment at the residential facility.	each nclude:	C) ADMINISTERTOR UP ON DEPLICATION IN COMPLICATION IN COMPLICATION VACAMA, JOD(1)() d) DOMINISTERTOR BE MONITORILE	on Toxion A-TLO
			Meas Pausoner	
			TO ensure view	1017671

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12/11/2008

Bureau of Licensure and Certification

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION
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(X3) DATE SURVEY
COMPLETED

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STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

1013 STONEYPEAK AVE

HOLY FAMILY ADULT CARE HOME LLC LAS VEG			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DEFICIENCY)  (X5)  COMPLETE DATE
Y 101	Continued From page 10	Y 101	HOS meet or langt cooper
	This Regulation is not met as evidenced b Based on personnel file review, there was date for 4 of 6 employees (Employee #1, # and #6).	no hire	Six monness and reven- ence the curing the diver Name con Prousers. L) androuse to was com-
	Findings include:		Plantay Lacion son NAC
	There was no documented evidence of a h date in Employee 1's file.  Employee #2, #3 and #6 did not have an employee file to review.	nire	80001 TOUR #2, #3 # 6 H BOORN TOUR MINATED BU HAGE FACILITED NOW EMPLOYER HOS WILLOW,
	Severity: 1 Scope: 3		8) ATTACISMENT #90, TAG
Y 102	449.200(1)(c) Personnel File - Training Red	cords Y 102	h) 4/28/09
	NAC 449.200  1. Except as otherwise provided in subsect a separate personnel file must be kept for emember of the staff of a facility and must in (c) Records relating to the training received the employee.	each nclude:	4102  Q) STOFF OF YER FACILITE  HOS INTOLMED AND GEO  COTE LEADUDING LEGON  MENTS OF NAC 449. 200 (1)  D) ADMINISTRATOR VILLE
	This Regulation is not met as evidenced by Based on personnel file review, the facility to ensure 6 of 6 employees received not let than 8 hours of training related to providing the needs of the residents (Employee #1, ##4, #5 and #6).	failed ss for	monitod peusonnes of the engues described in emplished is the formal of the engues of the emplished is the formal of the emplished is the formal of the engues of the emplished in the engues of the e
	Findings include:		BSOUR THAT FACULTE
	Employee #1 had an unknown date of hire. employee had documented evidence of 4 h of training in medication management on		Parlisonne DILE FOIL Cheed Enployees of

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS5002AGC

B. WING\_

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FAMILY ADULT CARE HOME LLC  1013 STONEYPEAK AVE LAS VEGAS, NV 89108		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)		
Y 102 Continued From page 11 Y 102 EUGERY SIX MONTHS FOR	7	
11/20/08		
d) employe #2, #3, #4, #5.	7	
Employee #2 had an unkπown date of hire.  There was no employee file to review.  # 35 Takkmin Area By the Focility to Resource and the second		
Employee #3 had an unknown date of hire.  There was no employee file to review.		
Employee #4 was hired on 9/2/08 per the		
Employee #4 was hired on 9/2/08 per the employee's statement. There was no employee	. N =	
file to review.	ح ک	
Employee #5 was hired on 9/2/08 per the		
employee's statement. There was no employee	>	
file to review.	i.	
Employee #6 had an unknown date of hire.		
There was no employee file to review.	10 5	
Severity: 2 Scope: 3		
Y 103 449,200(1)(d) Personnel File - NAC 441A Y 103 Y 103		
a) STATE OF THE FACELITE		
NAC 449.200		
1. Except as otherwise provided in subsection 2,	ने :	
be a filter of the factor of the factor of the same of		
(d) The health certificates required pursuant to		
chapter 441A of NAC for the employee.		
MAE 449.300(1)(d) 161		
con Rusice		
This Regulation is not met as evidenced by:	#E	
NAC 441A.375 Medical facilities, facilities for the		
dependent and homes for individual residential care: Management of cases and suspected		
cases; surveillance and testing of employees; カローカー	(چن	
counseling and preventive treatment.  To encounse we deduce the deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.	\	

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If continuation sheet 12 of 58

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2)	MUI	LTIE	PLE	CONSTRUCTION	

(X3) DATE SURVEY COMPLETED

NVS5002AGC

A. BUILDING
B. WING

12/11/2008

NAME OF PROVIDER OR SUPPLIER

## HOLY FAMILY ADULT CARE HOME LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

1013 STONEYPEAK AVE LAS VEGAS, NV 89108

HOLY FA	MILY ADULT CARE HOME LLC	GAS, NV 891	08
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE
	a:  (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and  (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination.  If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter,		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 13 of 58



Bureau of Licensure and Ce	ortification					: 01/15/2009 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER  NVS5002AGC					(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HOLY FAMILY ADULT CARE	HOME LLC	1013 STO	DRESS CITY S DNEYPEAK A AS, NV 891			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
documented evide the required tubero The employee file physical examinati that the employee was free from activ a contagious stage Employee #6 has a employee did not h was no documente received the require The employee file physical examinati	to review. There was nce the employee ha culin screening test. did not contain the re on or a physician cer was in a good state of the TB and any other of	esults of tification of health, disease in hire. The There oyee had ing test.	Y 103			

Severity: 2 Scope: 3

a contagious stage.

Y 104 449.200(1)(e) Personnel File - References

NAC 449.200

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 Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (e) Evidence that the references supplied by the employee were checked by the residential facility.

was free from active TB and any other disease in

This Regulation is not met as evidenced by: Based on personnel file review, the facility failed to investigate the references on 5 of 6 employees (Employee #2, #3, #4, #5 and #6). 4104

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Y 104

ASS INTOLLINED RECORDING REGULATION ON WHE ALP 200 (1)(B).

b) Dominicated to unce monitor fection of ensure percution of NAC 449. 200 (1) (C) 15 1.

com du ance.

e) ADMINISTRATOR WILL Se usua en plouse Checkist sol Parsonviel

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

If continuation sheet 16 of 58

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS5002AGC			(X2) MUL A. BUILD B. WING		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY	STATE, ZIP CODE	12/11/2000
HOLY F	AMILY ADULT CARE I	HOME LLC	1013 STO LAS VEGA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
Y 104	Continued From pa	ge 16		Y 104	700 (1)(e),	SIATE NAC 449.
	Findings include:				di) employee	# 2, # 3, # 4, # 5
	Employee #2 had a There was no empl	n unknown date of house file to review.	nire.		Musey new	- Employee.
	Employee #3 had a There was no employed	n unknown date of h oyee file to review.	nire.		were be c	1360 10 compu
	Employee #4 was h employee file to rev	ired on 9/2/08. Thei iew.	re was no		8) 4/28/09	
	Employee #5 was h employee file to rev	ired on 9/2/08. Thei iew.	re was no			i c
	Employee #6 had at There was no employee	n unknown date of h oyee file to review.	ire.		1.00	5
	Severity: 1	Scope: 3			105 a) 37054 OF	THE DECLITY
Y 105	449.200(1)(f) Perso	nnel File - Backgrou	nd Check	Y 105		00 (1) (f) 2eau.
	NAC 449.200 1. Except as otherw	ise provided in subs	ection 2			7887012 were
	a separate personne	el file must be kept for of a facility and mus	or each		NAC UMG.	200(1)(+) 18 14 ca miles 146
	449.185, inclusive.	,			Weenon	
	This Regulation is r NRS 449.176 Inves applicant for license 1. Each applical facility for intermedia	itigation of criminal h to operate certain fa nt for a license to op	istory of acility.		mon, to e 1550e q & 200 (1)(f)	DAT NOCHE
	nursing or residentia submit to the Centra Records of Criminal	al facility for groups s al Repository for Nev	shall ada e sets of		d) Admicing	THROUGH HAS 39

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A. BUILDING B. WING NVS5002AGC 12/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1013 STONEYPEAK AVE** HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES : PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) -1cg-82 FACILITY REGUIRED Y 105 Continued From page 17 Y 105 of Investigation for its report. 2. The Central Repository for Nevada Records of Criminal History shall determine whether the applicant has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188 and immediately inform the SEE COUIT. administrator of the facility, if any, and the Health Division of whether the applicant has been 7849 22 OF 58. convicted of such a crime. (Added to NRS by 1997, 442) NRS 449.179 Initial and periodic investigations of criminal history of employee or independent contractor of certain agency or facility. 1. Except as otherwise provided in subsection 2, within 10 days after hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall: (a) Obtain a written statement from the employee or independent contractor stating whether he has been convicted of any crime listed in NRS 449.188 (b) Obtain an oral and written confirmation of

the information contained in the written statement obtained pursuant to paragraph (a);

(c) Obtain from the employee or independent contractor two sets of fingerprints and a written authorization to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and

(d) Submit to the Central Repository for Nevada Records of Criminal History the fingerprints obtained pursuant to paragraph (c).

2. The administrator of, or the person

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 18 of 58



PRINTED: 01/15/2009 FORM APPROVED Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1013 STONEYPEAK AVE** HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) on employee stamme **BU** Y 105 Y 105 Continued From page 21 HEISUR HIS NOT BERVICEDALICE (a) Before it received the information OF THE CHIMES IN ACCOUDING concerning the employee or independent Lected NRS 4491,188 contractor from the Central Repository; 2) enouge +2, +3, +4,+5,+6 (b) During any period required pursuant to subsection 2 to allow the employee or HAS TOOCH MINDTEN BY THE independent contractor to correct that FACILITY and JURGED NEW information; (c) Based on the information received from Employee & courtender the Central Repository, if the information received A) ATTACHMENT #11 ITAG Y105 from the Central Repository was inaccurate; or (d) Any combination thereof. 9) 4/25/09 È An agency or facility may be held liable for any other conduct determined to be negligent or employee #1 lenewied the Doministed LICENSE unlawful. (Added to NRS by 1997, 443; A 1999, 1948 4857 7/31/07 AND TOULL Based on record review, the facility failed to PEDUOTTI OF VOLLTED CON ensure the criminal history for 2 of 6 employees FURINCED THAT HE DID NOT were investigated at least once every 5 years near snorted Fingal. (Employee #2 and #4), 6 of 6 employees had a PRINTING OR BACKGROUND written statement stating whether the employee had been convicted of the crimes listed in NRS essecul onger tota mext 449.188 (Employee #1, #2, #3, #4, #5 and #6), 6 Renewer on Misilog. of 6 employees had a verification letter from the state repository (Employee #1, #2, #3, #4, #5 and #6) and 6 of 6 employees had copies of fingerprints in the file (Employee #1, #2, #3, #4, #5 and #6).

Findings include:

Employee #1 had an unknown date of hire. The file indicated fingerprints were completed on 11/27/02. There was no documented evidence of fingerprints completed in 2007, no documented evidence of a signed statement stating whether he had been convicted of a crime, and no documented evidence of a verification letter from the state repository for 2007.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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FORM APPROVED Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1013 STONEYPEAK AVE** HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 105 Y 105 Continued From page 23 written statement stating whether the employee had been convicted of the crimes listed in NRS 449.188 or a verification letter from the state repository. Severity: 2 Scope: 3 4106 a) STATE OF THE STATULING HAS Y 106 Y 106, 449,200(2)(a) Personnel File - 1st aid & CPR intourned leader le 60000000 0= NAC 449,300 NAC 449,200 ( Jul (Oc) . 2. The personnel file for a caregiver of a residential facility must include, in addition to the b) ADVINISTUATOUR information required pursuant to subsection 1. MOMTOR FACILITY TO (a) A certificate stating that the caregiver is currently certified to perform first aid and enque no 1119, 2000 cardiopulmonary resuscitation. 15 in compulance we THE WELCHTON el moministratore FRENT BUDDER Compion This Regulation is not met as evidenced by: ensuce - 125 Based on personnel file review and interview, the AT LEBET Sux Elaceci facility failed to ensure 5 of 6 caregivers were SIX months DOR RE. trained in first aid and/or cardiopulmonary resuscitation(CPR) (Employee #2, #3, #4, #5 and Certification #6). Quiver By nacy49. 200 (2)(a) Findings include: d) emologe \$ 2, \$ 3, \$ 4.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Employee #2 had an unknown date of hire.

Employee #3 had an unknown date of hire.

Employee #4 was hired on 9/2/08. There was no employee file to review. The employee provided a copy of her CPR certification. The certification

There was no employee file to review.

There was no employee file to review.

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STATEMENT	OF	<b>DEFICIENCIES</b>
AND PLAN OF	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

2) MULTIPLE CONSTRUCTION		(X3) DATE
BUILDING		COM

(X3) DATE SURVEY COMPLETED

NVS5002AGC

B. WING

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FAMILY ADULT CARE HOME LLC

1013 STONEYPEAK AVE LAS VEGAS, NV 89108

HOLT FA	MILY ADULT CARE HOME LLC	AS VEGAS, NV 89	108	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 106	Continued From page 24	Y 106	8) 4/25/09	
	expired April 2010.			
	Employee #5 was hired on 9/2/08. There we employee file to review.	was no		
	Employee #6 had an unknown date of hire There was no employee file to review.			
	Employee #4 indicated she was aware she required to have first aid certification. The employee revealed she had not had time the course.			
	Severity: 2 Scope: 3			
Y 152	449.204(2) Insurance-BLC endorsement	Y 152	y 150 a) orninal was with	م الأربر من الأمار الأربر من الأمار الأربر
	NAC 449.204 2. A certificate of insurance must be furnish the Division as evidence that the contract required by subsection 1 is in force and a limust not be issued until that certificate is furnished. Each contract of insurance must contain an endorsement providing for a nor 30 days to the bureau before the effective a cancellation or nonrenewal of the policy.	icense st tice of	DECEMBER NAC (2) RECOVERNED D) DOWNING STUDGED MONITOR ROCORD 15 IN RECORD & THE HAST IS E FIND BUD BUSH.	449.
	This Regulation is not met as evidenced b Based on observation and interview, the fa failed to evidence of a Certificate of Liability Insurance Policy.	cility	C) BOWNING TU-STOR MUONITOR # BCIL ENSURE REGUL	1701 3
	Findings include:		18 14 complia	24 (ン) ことを、
	Certificate of Liability Insurance policy was available to review.	not	d) 025 bed ment \$	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 25 of 58

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Bureau o	f Licensure and Ce	rtification		т			IDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED			
		NVS5002AGC		B. WING		12/1	1/2008
	ROVIDER OR SUPPLIER	HOMELLO	1013 STON	IEYPEAK A			
HOLY FA	MILY ADULT CARE			S, NV 8910	PROVIDER'S PLAN OF CORF	PECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE
Y 152	Continued From p	age 25		Y 152			
	Employee #4 was policy.	unable to find the ins	urance				3
I	Severity: 1 Sco	pe: 3					
Y 251	449.217(2) Storag refrigerated	e of Food-Perishable	foods	Y 251	7251 a) 37877 00	1 Cashina	March and A
	temperature of 40	ds must be refrigerate degrees Fahrenheit st be kept at a tempe	or less.		217 (2), 217 (2), D) somin	CON OF	2 veces
					2) 18		449.21
	<ul> <li>Based on observa</li> </ul>	is not met as evidenc ation, the facility failed perishable foods.	ed by: d to ensure		e) 2/25/09		
	Findings include:						į
	were noted to be	1:00 AM, three chicke in a plastic container on the kitchen count	covered				
	were for her due chicken. The en defrosted the chi	s indicated the chicke to the residents did r aployee indicated she icken in the microway nable to say why she today.	not eat e usually ve. The				
	The residents at for lunch. The residents	e Filipino noodles and esidents indicated the served	d vegetables ey enjoyed		i		

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							: 01/15/2009 APPROVED
Bureau	of Licensure and Ce	rtification				FORIVI	AFFROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  NVS5002AGC			(X2) MULT A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF F	ROVIDER OR SUPPLIER	1 WOODDZAGO	STREET AD	DRESS, CITY,	STATE, ZIP CODE	12/1	1/2008
	AMILY ADULT CARE	HOME LLC		NEYPEAK AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
Y 251	Continued From pa	nge 26		Y 251	11277		
					4272 a) 30 AFF GET TO	48 F00	LLLITY
	Severity: 2	Scope: 3			Mar in For	rais a	E-CALLON
Y 272	449.2175(3) Service	e of Food - Menus		Y 272	n AC 1149, 277		
	1110 440 0475				rmonitol 26		
NAC 449.2175 3. Menus must be in writing, planned a v		week in		といらいせを ハ			
	advance, dated, po-	sted and kept on file			13 in com	SC. PICE	- in
	days.				Accoudence		الما بدوي
					De Guittoi		
		not met as evidence ion and interview, the ted weekly manus			e) Boninistu Set UP A		l .
	railed to provide da	ted weekly intellus.			meno to		
	Findings include:				Mis SACIO	LTC1 T	D come.De
	A menu was taped	to the side of the refi	rigerator.		wented n &	-C 449	217/31
	There were no date calender.	es or days of the wee	k on the	:	d) Dominist	LATOL	Luce
	Employee #4 indica	ated she did not follow	wa menu i		A GU TERS		
		ced what the resident			coups of	D Ver	TENIO
	Severity: 1 Sco	ppe: 3			90 Dous	in con	~ でいかへ
	Covering. 1 300	.pc. 0	į		verred nd	e 146	1.217/3
Y 274	449.2175(5) Service	e of Food - Substituti	ions	Y 274	2) ATTACU ma	الحد مرسم	3 500
					4252.	-	, , , , ,
	NAC 449.2175				8) 4/26/09		
	5. Any substitution	for an item on the m	enu must [		0) -1,010-1		

be documented and kept on file with the menu for at least 90 days after the substitution occurs. A substitution must be posted in a conspicuous

place during the service of the meal.

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 4274 Y 274 Y 274 Continued From page 27 a) STORE OF THE PACILITY Hos in Foremand eclesion This Regulation is not met as evidenced by: REGULATION OF WAC 449 Based on observation and interview, the facility 217(5) failed to provide written substitutions on the menu. b) Doministrations fuce montrove Theretire to ensur Findings include: NAC AUG. 217(5) 18 IN A menu was taped to the side of the refrigerator. compuner verter sore There were no dates or days of the week on the REGULATION calender. There was nothing written in for substitutions. 0) 00 ministre 0200 5 Chat U1 70 W TO USE 704 Employee #4 indicated she did not follow a menu. The employee cooked what the residents TITUTION BY THE requested or what she felt like cooking. The HE RE-QUILLY BY NAC employee was not aware she was required to 449,217(5) write the substitutions on the menu. d) ATORCHMENT & 14, TOG Severity: 1 Scope: 3 Y274 Y 434 0) 4/28/09 NAC 449.229 1434 a) state or age apercin 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the 4)85 ILIFOURNAS WEGGER facility for not less than 12 months after the drill. REGULATION OF 729/20 b) Dominis Tubrow This Regulation is not met as evidenced by: movietor Facility Based on record review, the facility failed to engue NAC 449 229 ensure that monthly evacuation drills were conducted on an monthly schedule for the past 1 16 un comprisate les of 12 months. THE REGULATIONS,

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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							APPROVED
Bureau o	of Licensure and Cer	rtification	<u></u>		**BASSEPPT**	<u></u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF F	POMPER OF CHERLIER	NVS5002AGC	L STREET AND	DESS CITY	STATE, ZIP CODE	12/1	1/2008
	ROVIDER OR SUPPLIER IMILY ADULT CARE I	HOME LLC	1013 STO	NEYPEAK AS, NV 891	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 434	Continued From pa	nge 28		Y 434	c) Doministe	945CF C	بيدو
	Findings include:	•			mismi Toll s		
	_		التحاضية		12900005 1	on me	nteres
	completed for Nove	mented evidence of ember 2008. The las			BASIS TO G		
	documented fire dri	ill was 10/10/08.			15 in com		
	Severity: 2 Sc	cope: 1			d) omociona	,	٢
V 441	440 220/7)(a) Sma	king Doliny		Y 441	434,229		1 200-1 Y
1 441	449.229(7)(a) Smo	King Policy		1 441	PC/8614 (e	)	
	policy on smoking i by the facility. The	the purpose of preven	ried out		441  a) 57 8 FF OF &  BBS 10 FOUR  OF NAC 44  b) 80 minus TOR 3  enever 5  enever 6  449. 329( 15 meet,  c) 20 minus To	ray se e. 22e( exercia exer	COLATO  I TO  I IS IN  UTLE VIE
	Based on observati	not met as evidence ion, the facility failed smoking was develop	to ensure		705720 L CLL.TY T	Shuoki Linding	164 700-

There was no documented evidence of a smoking policy posted within the facility.

Scope: 3

STATE FORM

Severity: 1

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If continuation sheet 29 of 58



							01/15/2009 APPROVED
Bureau o	of Licensure and Cer	rtification					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		NVS5002AGC	I		· · · · · · · · · · · · · · · · · · ·	12/1	1/2008
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
HOLY FA	MILY ADULT CARE	HOME LLC		NEYPEAK A AS, NV 891			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 444	Continued From pa	ige 29		Y 444	4 3 1 34		
	449.229(9) Smoke	-		Y 444	1444 a) STORE OF	~ AG. ~	est re
1 777	443.223(3) SHIOKE	Detectors			ABS INFORM		
	NAC 449.229				nge 449.22		
		s must be maintained is at all times and mu			b) sominist		
		e results of the tests			monitor 3		
	•• ••••	nust be recorded and	ď		ensere M		1
	maintained at the fa	acility.			15. In ean		
					74 20. G. C.		-
		not met as evidence			c) Agrainist		
		eview, the facility faile ectors were tested 2			endered who		1
		tober and Novembe			Honroted		1
	Findings include:				ensoue.	Freil	TU 15
	_				In com ?	u anc	E very
		imented evidence of the months of Octob			N 8-6 2146	1.229(	( )
	November 2008.		J. J	:	d) ATTACHMO		
	Severity: 2 Scope	: 1			Y 444		
Y 450	449.231(1) First Ai	d and CPR		Y 450	2) 4/25/09		
1							
	NAC 449.231				YASD		
	1. Within 30 days a				Q) 310#F OF -	14 F. E.	CILITY
l ·	administrator or ca				HB INFOUR	ed re	e su Du
	residential facility is the facility, the adn				2ªGWLATU		
	caregiver must be				449,231 (1	).	

STATE FORM

caregiver must be trained in first aid and cardiopulmonary resuscitation. The

advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an

equivalent certification will be accepted as proof of that training.

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NOC MUG, 23, (1)

b) somewister to a were

Engobe FACILITY

in compuonde unit

<u> </u>	O	
DER/SUPPLIER/CLIA	(V2) MULTIPLE CONSTRUCTION	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING
	NVS5002AGC	B. WING

12/1	11/	วก	ΛQ

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FAMILY ADULT CARE HOME LLC		1013 STON LAS VEGA			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL .	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 450	Continued From page 30		Y 450	c) comprover & 1, &s	485
				Tarkinington ong	NOUL
				empronee was	Dever
				d) sommisted orous	سوسوره
	This Regulation is not met as evidenced	d by:		ensule o rice	- U .
	Based on interview and record review, the			ELL PLOYER Cufare	
	failed to ensure 2 of 6 employees (Emploand #5) had evidence of current training			AT LEDST EXEURI	S
	aid and 1 of 6 employees (Employee #5)	) had		Menteds TO Es	27
	evidence of current training in Cardiopuli Resuscitation (CPR).	monary		PAR SEN bring	231/
	, ,			ond re-count	231
	Findings include:			2) 4/28/09	C-1-110
	Employee #4 was hired on 9/2/08. There	e was no		7) 4/1/8/0 /	
	employee file to review. The employees	showed		V533	
	documented evidence of a current CPR certification expired on 4/2010. The emp	plovee		a) 37022 02 milit 40	
	indicated she knew she needed a first ai	d		405 more 12-mes 120	e con Fi
	certification but had not had time to go to class.	o the		NAC 449. 260(1)(	~ \ /~ \
	ciass.			Receiver wy	415×1
	Employee #5 was hired on 9/2/08. There	e was no			
	employee file to review.			p) Dominicaron	
	Severity: 2 Scope: 3			meenital FACIL	4
				Enque noc 40	9,76c
Y 533	449.260(1)(g)(2) Activities for Residents		Y 533	(g)(2)18 in con	しからいぬ
				whome refre week	0-6-65
	NAC 440 202			C) 80mm, 3002 8002	muc
	NAC 449.260 1. The caregivers employed by a residen	ntial		muchital French	CU TO
	facility shall:			Ensule in con	
	(g) Post, in a common area of the facility			In & month-cy	
	calendar of activities for each month that residents of the major activities that will of			THE TACK, THE	
	the facility. The calendar must be:			ACTIVITIES FOR	
	(2) Kept on file at the facility for not le	ess than		POSTED and KE	
	6 months after it expires. are cited, an approved plan of correction must be			FILES DT LEBY	io rui

STATE FORM

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If continuation sheet 31 of 58

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		COMPLETED
	NVS5002AGC	B. WING	12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1013 STONEYPEAK AVE

TOLT FA	AMILY ADULT CARE HOME LLC	AS VEGAS, NV 891	08	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 533	Continued From page 31	Y 533	OF RECOUND DETERL	. ' '
			d) or see many + 18,5	PC 1233
			2) 4/28/09	, -
	This Regulation is not met as evidenced by Based on observation and interviews, the failed to provide at least 10 hours of activitie 3 of 3 residents (Resident #1, #2 and #3).	acility		
	Findings include:			
	There was no documented evidence of an schedule in the facility.	activity		
	Employee #5 indicated he offered to take re #1 out of bed and into the living room to wa television if he wished.			
	Employee #4 was unsure why there was no activity schedule, During the survey, the residents were not offered involvement in a activities.			
	Resident interviews revealed no issues reg activities.	arding		
	Severity: 1 Scope: 3			
Y 623	449.2702(4)(d) Admission Policy	Y 623	4623 a) or of of the fa	سان د د د د
	NAC 449.2702		by intounce w	ceauji
	4. Except as otherwise provided in NAC 44		NA C 449, 2702 (2	
	and 449.2754, a residential facility shall not or allow to remain in the facility any person		b) sommestees tole	ane
	(d) Requires skilled nursing or other medical		mon row For	سر سوا
	supervision on a 24-hour basis.		TO ENGULE THA	TNAC
			449.2702(4)(4)	
			compuence su	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM 6C3E11



If continuation sheet 32 of 58

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STATEMENT OF DEFICIENCIES	-16
AND PLAN OF CORRECTION	I,

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVS5002AGC

A. BUILDING \_\_\_\_\_\_

12/11/2008

NAME OF PROVIDER OR SUPPLIER

HOLY FAMILY ADULT CARE HOME LLC

STREET ADDRESS CITY STATE ZIP CODE

1013 STONEYPEAK AVE LAS VEGAS, NV 89108

HOLY FA		S VEGAS, NV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		FIX	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)	TE
Y 623	Continued From page 32	Y 623	3	· PACILITY.	
				c) someristeated will	
				mo moral decident	
	This Regulation is not met as evidenced by Based on observation, interview and record			HIP, Domission view	0
	review, the facility failed to ensure appropria			to enecute use 149.	- [
	admission of a resident (Resident #1).			12702(4)(D) 15 in compu	1
	Findings include:			very use we we now	٠
	r mangs morade.			34 rue Aperlian.	
	Resident #1 was admitted on 8/17/08 with	ant		d) or dei man; #19, 704	F3-3
	diagnoses including Cerebrovascular Accide Hypertension, Dysphagia, Chronic Obstructi Pulmonary Disease, Osteoarthritis of the sp Depression, Dementia secondary to stroke, Diabetes II.	ive ine,		2) 4/28/09	
	The resident indicated he was unable to car his gastrostomy tube. The resident was completely dependent on staff for oral care, shaving, bathing, dressing, feeding, shaving toileting and medication administration per tradmission activity of daily living assessment completed on 8/17/08.	j, the			
	The Physician Statement dated 8/1/08 state "May use feeding tube for medicine delivery unable to swallow appropriately at anytime. Needs to have distilled water given through feeding tube given at 10 ounces every 4 hot except with sleeping".	' if			
	On 12/11/08 at 12:25 PM, Employee #5 demonstrated providing water to the residenthrough the gastrostomy tube (g-tube). The employee took water from the water cooler. Wearing gloves and a mask, the employee ounces of water and slowly pushed the water through the g-tube. The resident was sitting upright at the side of the bed. The employe indicated he did this three times a day with resident was sitting upright.	took 2 er g			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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RECEIVED sheet 33 of 58

Bureau o	f Licensure and Cer	rtification					<del></del> -
STATEMEN1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU!		A. BUILDING		(X3) DATÉ SU COMPLE	TED
		NVS5002AGC		B. WING _		12/1	1/2008
NAME OF P	ROVIDER OR SUPPLIER		•	- 3	STATE, ZIP CODE		
HOLY FA	MILY ADULT CARE	HOME LLC		NEYPEAK A AS, NV 8910			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
Y 623	Continued From pa	age 33		Y 623			
	a nurse came to vi- to change the g-tul blood sugar and ch pressure. The em	5 PM, Employee #4 is sit the resident 1 time oe dressing, check the neck the residents bloployee indicated sheing or add tape to the	e a week e capillary ood would				
	documentation from	dents record revealed m the physical therap note from a registered indicating the vital si	oist. The distance				
	Severity: 2 S	cope: 1		 	4645 a) STOFF 05	5-4cm	DCLL. TC
Y 645	449.2704(1) Rate	Agreement		Y 645	4) 16 14 700 COUCHE NACAGO	see our	une,
	upon request, mal	of a residential facilit ke the following inform to the services provide	nation		120-60 com b) 80mine mont 7012 TO senso	nons, states	2 mil
	Based on record reprovide a rate agree	s not met as evidence eview, the facility fail eement for 1 of 5 res	ed to		d) ADMINICOUNTO	184 700 GU YOU SOUL YOU	C FACE
	reviewed(Residen Findings include:	n #4).			N & C 44	9.2704.	

Resident #2 was admitted on 9/11/08. There was

no documented evidence of a signed rate

STATE FORM

If continuation sheet 34 of 58



d) ATTACHMENT

YGA5

12/11/2008

Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION

(X3) DATE SURVEY COMPLETED A. BUILDING

NVS5002AGC

NAME OF PROVIDER OR SUPPLIER

B. WING \_ STREET ADDRESS, CITY, STATE, ZIP CODE

		1013 STONEYPEAK AVE LAS VEGAS, NV 89108				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 645	Continued From page 34		Y 645	e) 4/28/09		
	agreement.					
	Severity: 1 Scope: 1					
Y 662	449.2706(2) Transfer of Resident		Y 662	1662 a) 570= 4 0 4 44 4	1	
:	NAC 449.2706(2) A resident, his next of kin and the response agency, if any, must be consulted and a arrangements must be made to meet the resident's needs through other means the permanently leaves the facility.	adequate he		Enjoye THAT	149,27 149,27 12 were 174 70 106(2)	
	This Regulation is not met as evidence Based on interview and record review, failed to ensure documentation indicationadequate arrangements must be made the resident's needs (Resident #4 and in the resident	the facility ng to meet		c) AT MINISTRATOR  monital cross  Densure was	12 week	
	Findings include:  Resident #4 was admitted on 2/20/08 vidiagnoses including Hypertension, Inschiperting Hyperlipidemia, Right Hemipelvis Fractions Generalized Debility.	omnia,		Dulance us n Tulance us n Tulans for to	a Discus	
	Employee #4 indicated the resident wad discharged on 12/5/08 to a local Assist Facility. The employee indicated the of (Employee #2) was at the facility the dataser and handled the resident move	ted Living wner ay of		4) 2778eisment T894662 2) 4/2609	21,	
	The resident file did not contain a date any documentation regarding a transfe facility. The last documentation on the	er out of the		the managed of deficiencies		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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If continuation sheet 35 of 58

STATEMENT OF DEFICIENCIES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	
A RUILDING	

(X3) DATE SURVEY COMPLETED

NVS5002AGC

B. WING

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1013 STONEYPEAK AVE

102117	AMILY ADULT CARE HOME LLC	AS VEGAS, NV 891		<del></del>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 662	Continued From page 35	Y 662		
	Medication Administration Record was 12/5	5/08.		
	Resident #5 was admitted on 1/27/08 with diagnoses including Early Parkinson and Early	arly		**
	Employee #4 indicated the resident was discharged on 12/5/08 to a local Assisted L Facility. The employee indicated the owner (Employee #2) was at the facility the day of transfer and handled the resident move.	•		
	The resident file did not contain a date of bi any documentation regarding a transfer out facility. The last documentation on the Medication Administration Record was 12/5	of the		
	Severity: 2 Scope: 3		1680	
Y 680	449.271(1) Gastrostomy Care	Y 680	SOF SOF TO FEBTO (D)	1
			educate selar	
	NAC 449.271 Except as otherwise provided in NAC 449.2	2736 a	426,000 com 0	a NA
	person must not be admitted to a residentia		449.271(1)	
	facility or permitted to remain as a resident residential facility if he:	ofa	b) so ministrator	ucce
	Requires gastrostomy care.		wow, god the	LLTLI
			TO Encode no	e. 449
			271(1) 12 in co	JAPAR
	This Developing is not used as evidenced by		c) sominietesto	
	This Regulation is not met as evidenced by Based on observation, interview and record	1	3ª cefeciente à	Carlos Co
	review, the facility failed to ensure appropria placement of a resident who required	ate	Be celecularly on	Lu
	gastrostomy care (Resident #1).		10 Eug. 02 € F.	ACL : -
	Findings include:		15 in complete	anc &
	i manga molado.		ready NAG 44	

if deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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If continuation sheet 36 of 58



STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION	(X2)	MULTIPLE	CONSTRUCTION
----------------------------	------	----------	--------------

(X3) DATE SURVEY COMPLETED

NVS5002AGC

A. BUILDING B. WING

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FA	MILY ADULT CARE HOME LLC		NEYPEAK AV AS, NV 89108	<del>-</del>	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 680	Continued From page 36		Y 680	Reidionous.	
	Resident #1 was admitted on 8/17/08 widiagnoses including Cerebrovascular Adhypertension, Dysphagia, Chronic Obst Pulmonary Disease, Osteoarthritis of the Depression, Dementia secondary to stropiabetes II.	ccident, ructive e spine,		(d)	
	The resident indicated he was unable to his gastrostomy tube. The resident was completely dependent on staff for oral c shaving, bathing, dressing, feeding, sha toileting and medication administration padmission activity of daily living assess completed on 8/17/08.	are, ving, per the			
	The Physician Statement dated 8/1/08 stated "May use feeding tube for medicine delivery if unable to swallow appropriately at anytime. Needs to have distilled water given through feeding tube given at 10 ounces every 4 hours except with sleeping".				
	On 12/11/08 at 12:25 PM, Employee #5 demonstrated providing water to the resthrough the gastrostomy tube (g-tube). employee took water from the water conversing gloves and a mask, the emploisences of water and slowly pushed the through the g-tube. The resident was supright at the side of the bed. The emploindicated he did this three times a day was a simple of the provided that the side of the bed.	ident The oler. yee took 2 water itting loyee			
	On 12/11/08 at 3:35 PM, Employee #4 a nurse came to visit the resident 1 time to change the g-tube dressing, check the blood sugar and check the residents blood sugar and check the residents blooressure. The employee indicated she change the dressing or add tape to the needed.	e a week le capillary lood would			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

STATE FORM

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If continuation sheet 37 of 58

Bureau of	Licensure and Cer	tification		Т		1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS5002AGC			(X2) MULTIP A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED  12/11/2008		
NAME OF BR	OVIDER OR SUPPLIER	111000011100	STREET ADDI	RESS, CITY, ST	TATE, ZIP CODE		
	MILY ADULT CARE	HOME LLC		EYPEAK A' S, NV 8910	8		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 680	Continued From pa	age 37		Y 680			
	documentation from	lents record revealed in the physical therap note from a registered indicating the vital sig	ist. The I				
,	Severity: 2 S	cope: 1			1859		
Y 859	449.274(5) Periodi resident	c Physical examination	on of a	Y 859	a) STOFF OF TOUR	en) vecil	read met;
	admission, or mor- significant change resident, the facilit general physical e his physician. The	on and each year after e frequently if there is in the physical condi- y shall obtain the res- xamination of the res- e resident must be ca structions provided by in.	tion of a ults of a ident by red for		DI SOMINISTOR  MEDNITOR  CHROLE T  15 IN COM  THE DECK  E) STIMINIS  MICHITOR	THE HA	e, 274 (c)
					The TO	e usu	en men
	Based on interview failed to obtain the	s not met as evidence w and record review, e results of an initial p of 5 residents (Resid	the facility ( hysical		nde 44 compen advance	e. 274 Ance ?	(5) 18 17 Dece
	Findings include:				EUG 02=	_	1
	resident's record	admitted on 9/11/08. failed to provide docu esults of an initial phy 008.	mented		eron a	enden.	Talir
	Severity: 2 So	ope: 1			~) ~(/s/	~~ 	

STATE FORM

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If continuation sheet 38 of 58

Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1013 STONEYPEAK AVE** HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 870 Y 870 Continued From page 38 Y 870 449.2742(1)(a)(1) 449.2742(1)(a)(1) Medication Y 870 4870 a) got but of rue whelling Administration 408 (noulman) exercióne REGULATION OF NACHUR. NAC 449.2742 2742 (1/a)(1). 1. The administrator of a residential facility that provides assistance to residents in the D) ADMINISTLATOUR feeler administration of medications shall: MEDINITION SPECIFICATO (a) Ensure that a physician, pharmacist or en sour nac 111 (1274)(1 registered nurse who does not have a financial interest in the facility: (a) (1) is in combine (1) Reviews for accuracy and The red reda the air atton appropriateness, at least once every 6 months C) AD MINISTERTOR the regimen of drugs taken by each resident of the facility, including, without limitation, any ensure type Their over-the-counter medications and dietary supplements taken by a resident. vere Be usure man cotton verseu FOUNTO COMPLY WILL WAC 149.2242 (1)(a)(i RELIVERTIONS. This Regulation is not met as evidenced by: a) sommester of the Based on interview and record review, the facility failed to ensure that a medication profile review monitour reset unas was performed by a physician, pharmacist or registered nurse at least once every six months charon well he exte for 2 of 2 residents residing in the facility for AT LELAST Ewaciel Sik longer than six months (Resident #4 and #5). Much tods Attaced 40 -Findings include: VIVILSSION TO compe werry refe vegouso Resident #4 was admitted on 2/20/08. There was 2) ATT ACS MENT \$ 22, no medication profile review in the record. Resident #5 was admitted on 1/27/08. There was no medication profile review in the record. PO1 14 1K

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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FEC If confine to sheet 39 of 58

Severity: 1 Scope: 2

Bureau o	<u>f Licensure and Cei</u>	tification		<del></del>		T	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  NVS5002AGC		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
			l		12/1	1/2008	
NAME OF PR	ROVIDER OR SUPPLIER		l .		STATE, ZIP CODE		
HOLY FA	MILY ADULT CARE	HOME LLC	1013 STO	NEYPEAK AS, NV 891	08		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	Continued From pa			Y 877 Y 877	1877 @ 80000 05	nder Fac	
Y 877	449.2742(5) OTC ( Supplements	medications & Dietar	y	1 0//	HAS INFOUR	nes ve	abildinc
	NAC 449.2742				2745(5),		
<ol><li>An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the</li></ol>				MOUNTAL	FACILI	14 70	
	administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medication and dietary				(5) 15 In	_	
					c) porning		
					monitor	MAL TA	o e vision
	supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744.  This Regulation is not met as evidenced by: Based on record review and interview, the facilities.		subsection		MAC AUG.	met &	7
					Ch) Domini		ueice
					morrisol	48 BY	and or
			the facility		Moder if	ou su	e Jan
failed to obtain physician orders to adm over-the-counter (OTC) medications for residents (Resident #2).	or 1 of 3	1	Ducksic	a Arvi -			
Resident #2 was admitted on 9/11/08.			Calcium		2) 4/28/00	7	
	600 with Vitamin D 1 tablet daily and Women's One Daily Vitamin 1 tablet daily were observed in the medication drawer and documented on the Medication Administration Record. There was no						 
documented evidence of a physician of medication.			order for the		,		
	brought the medi	icated the residents of cation to the facility to the ployee was not awa	o give to the				

If deficiencies are cited, an approved plan of correction mu 6899

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PRINTED: 01/15/2009 FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS5002AGC 12/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 877 Y 877 Continued From page 40 was needed by the physician. Severity: 2 Scope: 1 1878 Y 878 Y 878 449.2742(6)(a)(1) Medication / Change order al = 100 400 FACILITY HAS INFORMED REGIONATIONS NAC449.2742 (6)(2)(1) NAC 449.2742 REGULATION 6. Except as otherwise provided in this subsection, a medication prescribed by a DISPANTATION (d) physician must be administered as prescribed by monitor FACILITY the physician. If a physician orders a change in TO ENGUE NACHUE. the amount or times medication is to be administered to a resident: N &1 (1) (2)/2) 6 DTG (a) The caregiver responsible for assisting in the compliance refine to administration of the medication shall: KERULATION (1) Comply with the order. e) ooministreptor will MIONITON RESIDENT'S MANZ TO ENSURE FACULIEU 15 14 com This Regulation is not met as evidenced by: Primice with Based on record review the facility failed to ensure the medication prescribed by a physician REELDLOTION. was administered as prescribed for 3 of 5 d) BOWINISTON CESresidents (Resident #1, #2 and #3).

Findings Include:

STATE FORM

Resident #1 was admitted on 8/17/08 with diagnoses including Cerebrovascular Accident, Hypertension, Dysphagia, Chronic Obstructive Pulmonary Disease. Osteoarthritis of the spine. Depression, Dementia secondary to stroke, and Diabetes II.

Resident #1 had an order for Sertraline 100 milligrams (mg) 1 tablet to be given at bedtime.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau o	f Licensure and Cer	rtification	<del></del>	<del> </del>			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER  NVS5002AGC		R/CLIA MBER	A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE		
			B. WING		12/11	/2008	
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		!
	MILY ADULT CARE	HOME LLC	1013 STON	NEYPEAK AV	3		
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETE DATE
	Continued From particles of the Medication Adagust, September 2008 in tablet daily at 8 AM Resident #1 had a bedtime. The MAI October, November indicated Plavix 75 Employee #4 indicated Plavix 75 Employee #4 indicated for each more MAR for each more MAR for each more MAR indicated the MAR indicated 8 AM and 8 PM.  Employee #4 indicated 8 AM and 8 PM.	age 41 Iministration Record or, October, November of Cotober, November dicated Sertraline 10 M. In order for Plavix 75 R for August, Septemer and December 2005 mg 1 tablet daily at cated she was aware by the series of the cated of the cate	(MAR) for er and 10 mg at on the er and 10 mg 1 mg at on the er and the er and the er and she er an		BEFICIENCY)  BOUM HAS BO  ENGLE  WICET.  H 178/09		10 10 N
	indicated Guiatus There was no tin	s 100 mg 2 tsp every ne indicated on the M	tour nours. IAR and		i de la		

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Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Y 878 Y 878 Continued From page 42 initials placed one time a day from December 4 through December 10. Resident #3 had an order for Furosemide 20 mg 1 tablet daily and Potassium 10 milliequivilents daily. Neither medication were on the November 2008 or December 2008 MAR. Employee #4 indicated the resident received the medication each day. The employee indicated the owner did not include a MAR for those medications. Severity: 2 Scope: 3 4879 Y 879 Y 879 449.2742(6)(a)(2) Medication / Change order a) 318 = 0 + 48 = 5011114 485 INFORMED FACILITY 2000 Mac 449.2743 (6)(a)(2) reconstron. NAC 449.2742 6. Except as otherwise provided in this b) sominismestal will mo subsection, a medication prescribed by a TOUR THEILITY TO ENGULE physician must be administered as prescribed by nae 449.2742 (6)(2) 15 the physician. If a physician orders a change in the amount or times medication is to be in compliance final administered to a resident: THE WELLLATION (a) The caregiver responsible for assisting in the administration of the medication shall: C) ADMINISTRATOR LIVE (2) Indicate on the container of the medication monisor Har closerd that a change has occurred. TO EUGULES 4VOT VIAC MAG, 2742 (6)(a) (2) REGU

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on review of the medication administration

changed for 1 of 3 residents (Resident #3).

record (MAR) and observation of the medication

bottle, the facility failed to indicate on a container of medication a medication dose had been

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PRINTED: 01/15/2009 **FORM APPROVED** Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) PIBLADOLCE # TUSHERSHIP Y 879 Y 879 Continued From page 43 P0/8-8/12 /4 Findings include: Resident #3 was admitted on 8/9/08 with diagnoses including Hypertension, Urinary Frequency, Gait Imbalance, history of falls, Chronic Obstructive Pulmonary Disease, Depression, Insomnia, Osteoporosis, Grave 's Disease, Hypothyroidism and Weight Loss. Resident #3 had an order for Guiatus 2 teaspoons (tsp) every 4 hours written on 11/25/08 by the hospice physician. The bottle label indicated Guiatus 2 tsp every 4 hours as needed for cough. The MAR for December indicated Guiatus 100 mg 2 tsp every four hours. There was no time indicated on the MAR and initials placed one time a day from December 4 through December 10. The label on the medication bottle did not indicate a change in the order. Severity: 2 Scope: 1

Y 885

NAC 449.2742

STATE FORM

Y 885 449.2742(9) Medication / Destruction

9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449,2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication.

1885 a) STORE OF THE FACILITY

HAS INFORMED LEAKEDING NAC 449.2742 (9) DEGU-LA-57021

b) soministestal vive MONITOR FACILITY TO curve in compliance MAC 449 3743 (0

REGULATION IS MET. c) sommisterore luce Check mad to ensur The madication were is

DESTROY IN A PUOYOUR If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Licensure and Certification (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1013 STONEYPEAK AVE** HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) 1D PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) WHILL BUT DECENTABLE Y 885 Y 885 Continued From page 44 BOSING DIC MEDICATIONS. d) ADMINISTRATOR WELL BESOUR THAT TACKLITED WELL This Regulation is not met as evidenced by: BE USING HEDICATION Based on observation and interview, the facility DESTUUCTION LOG FORMS failed to destroy medications after they were 2884 2017 46 A 24 Marie 4 34, TOC 1885 discontinued, had expired or after a resident had been transferred. X 4/28/09 Findings include: Resident #2 was admitted on 9/11/08. Dok Plus. Metoprolol and Morphine Sulfate were found in the medication container. The medications were not found on the December 2008 Medication Administration Record. Employee #4 revealed the medications were discontinued when the resident was discharged from Hospice services. The employee indicated the hospice nurse would take away the medication when it was discontinued. There was no hospice record to review. The employee indicated she did not feel comfortable throwing away the medication. The employee indicated the owner should be the person to destroy the medication. On 12/11/08 at 12:15 PM, the hospice nurse indicated the medications were not discontinued. only the services. Resident #3 was admitted on 8/9/08. On 10/27/08 Senna S was discontinued. On 12/8/08 Miralax was discontinued. Both medications remained in the medication closet.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Employee #4 indicated she did not feel

comfortable throwing away the medication. The employee indicated the owner should be the

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If continuation sheet '45 of 58

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FORM APPROVED Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A. BUILDING B. WING NVS5002AGC 12/11/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) Y 885 Continued From page 45 Y 885 person to destroy the medication. Severity: 2 Scope: 2 4899 Y 899 Y 899 449.2744(2) Medication Administration a) STOTE OF THE FACILITY insolmed eacher Dice NAC 449.2744 NAC449, 2744 (2) 4 & 4014 The administrator of the facility shall keep a log of caregivers assigned to administer medications b) soministector rece that indicates the shifts during which each caregiver was responsible for assisting in the monitor FACILITY TO administration of medication to a resident. This ensure nae 449. 2744/2 requirement may be met by including on a 12 in comproned with resident's medication sheet an indication of who assisted the resident in the administration of the Mª LEAULOTON medication, if the caregiver can be identified from c) Doministestok fill this indication. angule who contaction HAS TECHNICO DUBLE WILL Decoupie JAMINI PLUSHY LU in compliance in Vegeren Tol 449,2744(2),

This Regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain accurate medication documentation.

Findings include:

Resident #1 was admitted on 8/17/08. During review of the Medication Administration Record (MAR), the surveyor noted the initials of ET and RT were written on the MAR for December 2008. Review of the MAR for September 2008, October 2008 and November 2008 also contained the initials of ET and RT. No documented evidence of a signature confirming the initials written on the

TO covers pond

d) 4/28/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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Bureau of Licensure and Certification STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS5002AGC

B. WING

12/11/2008

	11433002AGC		12:	11/2000		
NAME OF P	ROVIDER OR SUPPLIER ST	REET ADDRESS, CITY,	STATE, ZIP CODE			
		)13 STONEYPEAK AS VEGAS, NV 891				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 899	Continued From page 47	Y 899				
	medications. The employee reiterated she only writing the owner's initials until she tool medication course.					
	Employee #2 had an unknown date of hire. Employee #2 was one of the owners of the facility. Employee #4 notified Employee #2 surveyor from the Bureau of Licensure and Certification was in the facility. Employee #4 indicated she was unaware of Employee #4 her and Employee #3's signature (husband Employee #2 and part owner). The employ indicated her husband (Employee #3) set the procedure. The employee expressed she hidea why her husband set up the procedure Employee #4.	to the state of th				
	Severity: 3 Scope: 3					
Y 930	449.2749(1)(a) Resident File	Y 930	495. INFORMED RE	Lancing Ed Ale Dine		
	NAC 449.2749  1. A separate file must be maintained for earesident of a residential facility and retained least 5 years after he permanently leaves the facility. The file must be kept locked in a plat that is resistant to fire and is protected again unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related the resident, including without limitation:  (a) The full name, address, date of birth and social security number of the resident.	for at ne	NACA49. 2749 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	2) 2240 2749(1 2 12446 2 1246 2 12		
	This Regulation is not met as evidenced by Based on interview, the facility failed to ensiresident records were retained for at least 5 years.	ure all	DISEABUCE.  d) 4/28/09	l l		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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PRINTED: 01/15/2009 FORM APPROVED Bureau of Licensure and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING 12/11/2008 NVS5002AGC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1013 STONEYPEAK AVE HOLY FAMILY ADULT CARE HOME LLC LAS VEGAS, NV 89108 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Y 930 Y 930 Continued From page 48 Findings include: On 12/11/08 at 10:15 AM, Employee #4 was requested to provide the surveyor with all discharged or transferred residents from January 2008 to the present. The request was made several times to the employee. At 4:15 PM, the employee indicated she could not find any resident records other than the 2 residents who were recently discharged from the facility. Severity: 2 Scope: 3

Y 933

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## NAC 449.2749

Y 933 449,2749(1)(d)(1) Resident File

1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:

(d) A statement from the resident's physician concerning the mental and physical condition of the resident that includes:

(1) A description of any medical conditions which require the performance of medical services.

This Regulation is not met as evidenced by:
Based on record review, the facility failed to

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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note 449.2749 (1) (d) (1) 22

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b) ADMINISTRATOR LILLE

MEDNITOR FREILITH 50

GUSCALE NAC 449.2749(1

(d) (1) 15 in compliance

WING THE REGULATION

C) ADMINISTRATOR LILLE

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Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED	
NVS5002AGC					12/1	1/2008	
HOLV FAMILY ADULT CARE HOME LLC			DORESS, CITY, STATE, ZIP CODE ONEYPEAK AVE GAS, NV 89108				
PREFIX (EACH DEFIC	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			D PROVIDER'S PLAN OF CORRE EFIX (EACH CORRECTIVE ACTION SH AG CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETE DATE	
Findings included Resident #2 was no documented statement in the	cian statement was comes (Resident #2). e: as admitted on 9/11/08. d evidence of a physician e residents record. Scope: 2	There was	Y 933	Y936	2		
NAC 449.2749 1. A separate fresident of a releast 5 years a facility. The file that is resistant unauthorized unrecords, letters information and the resident, in (e) Evidence of chapter 441A chadopted pursual This Regulation NAC 441A.380 follows: 441A.380 1. Exsection, before medical facility or intermediate ensure that a chadopted pursual to the facility. 2. Except as of	ile must be maintained for sidential facility and retained from the permanently leaved must be kept locked in the to fire and is protected se. The file must contain, assessments, medical any other information recluding without limitation from pliance with the proof NRS and the regulation	ined for at es the a place against n all elated to consistency of the against of		a) 57 877 07 07 07 07 07 07 07 07 07 07 07 07 0	HOUL IN ACHAGE VE ON PER LAND LE VE ON PER LAND LE VACAL LA VAC	4000 mg  1000 mg  100	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies

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Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVS5002AGC

A. BUILDING \_\_\_\_\_\_\_B. WING \_\_\_\_\_\_

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## HOLY FAMILY ADULT CARE HOME LLC

1013 STONEYPEAK AVE LAS VEGAS, NV 89108

		AS, NV 891		į
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 53  contain documented evidence the resident completed the second step  Severity: 2 Scope: 3	Y 936 Y 941	.10/11	
Y 941	NAC 449.2749  1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation:  (h) A list of the rules for the facility that is signed by the administrator of the facility and the resident or a representative of the resident.		1941  a) STATE OF THE FACE  HAS INFORMED USE  NAC HA 9. 274 9 (1)  VEROLATIONS  b) DOMINISTRATOR  ENRULE NAC 449.  (h) 18 IN COMPL  VERULE VERL  C) DOMINISTRATOR  NONITOR VERSIT  THE 15 COMPLE  POUL BOMISSION  1941.	(h)  1216  1
	This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to have the rules of the facility signed by the administrator of the facility and/or the resident for 2 of 5 residents (Resident 1 and #5)		0) 4/28/09	- C
	Resident #1 was admitted on 8/17/08. Review of the records failed to provide documented evidence the rules of the facility were signed by the administrator of the facility and the resident.			
_	Resident #5 was admitted on 1/27/08. Review of			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 54 of 58



Bureau o	of Licensure and Cer	rtification		·		<del>                                     </del>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIF A. BUILDING B. WING	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED 12/11/2008			
		NVS5002AGC	STREET AND	RESS CITY S	TATE, ZIP CODE	12000	
	ROVIDER OR SUPPLIER	HOME LLC	1013 STO	NEYPEAK A	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 941	Continued From pa	age 54		Y 941			
	evidence the rules	o provide documente of the facility were sight of the facility and the r	gned by				
	Severity: 1 S	cope: 3					
Y 944	449.2749(2) Resid	lent File / Discharge		Y 944	1944 a) STATE OF	75 KST	JCICIT (
	(j) of subsection 1 which the resident in whose care the resident dies while document must in death and the date	required pursuant to pursuant to pursuant indicate the local was transferred or the resident was discharged a resident of the faction of the faction of the faction which the person death.	ation to ne person ged. If the ility, the ate of the on		20000000000000000000000000000000000000	THER.  1 MCE.  1 MCE.  1 DITO.	174 16 1111 16 1111 16
	Based on record redid not provide protwo residents who (Resident #4 and Findings include:		the facility regarding d		e) 4/28/0°	Ì	T
	discharge and de	dence of documentat stination after Reside discharged 12/5/08. be: 1	ion of the nt #4 and				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 55 of 58

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Bureau of Licensure and Ce	ertification					01/15/2009 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  NVS5002AGC			(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	4	
HOLY FAMILY ADULT CARE	HOME LLC		NEYPEAK AS, NV 891			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPROPRIEM OF THE APP	ULD BE	(X5) COMPLETE DATE
Y1001 Continued From pa	age 55		Y1001			
Y1001 449.2758(1) Traini	na Requirements		Y1001	41001		
	3 1			( PERAPS (9)	where are	hell re
NAC 449.2758				485 14702V		
1. Within 60 days a	after being employed			NAC 449.27		
	or elderly or disabled eceive not less than 4			D) ADMINISTUA		
	the care of those resi			monroe		
2 As used in this	section, "residential	facility for		GNSULE N		
elderly or disabled	persons " means a	residential		REGULATION	vi 15- ir	com
	es care to elderly or di re assistance or prote			Dumce 1	& moe	₹ •
	se they suffer from in			c) Dominion	28-501	mue
or disabilities.				88 08 1. L.	A7-56e	iden cen
				並るいるに、りい		
				2 EAUCONO	) M LS- 1	nat
				Brog Eng	es man	7 PG 7
				4101 15	- C-50	O cono
				Valued Wy	१८ यम्	1.27581
				12 2 GUC BA	ous.	`
Based on record re ensure a minimum to the care of elder received within 60	not met as evidence eview, the facility faile of 4 hours of training rly and disabled resid days of hire for 5 of oyee #2, #3, #4, #5 ar	ed to g related ents was 6		2 2 4 1 2 8   0 9		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of defliciencies. IV E D

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If continuation sheet 56 of 58

Findings include:

Employee #2 had an unknown date of hire. There was no employee file to review.

Employee #3 had an unknown date of hire. There was no employee file to review.

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES
STATEMENT OF DEFICIENCIES
AND DUAN OF CODDECTION
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION
(*.=,	•

(X3) DATE SURVEY COMPLETED

NVS5002AGC

Μ.	BUILDING	
В.	WING	

12/11/2008

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HOLY FAMILY ADULT CARE HOME LLC

1013 STONEYPEAK AVE LAS VEGAS, NV 89108

HOLY FAMILY ADULT CARE HOME LLC			GAS, NV 89108				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE				
Y1001	Continued From page 56	Y1001					
	Employee #4 was hired on 9/2/08. There employee file to review.	was no					
	Employee #5 was hired on 9/2/08. There employee file to review.	was no					
	Employee #6 had an unknown date of hire There was no employee file to review.	<b>.</b>					
	Severity: 2 Scope: 3						
Y1020	449.2766(1) Chronic Illness Training	Y1020	1000				
	NAC 449.2766  1. Within 60 days after being employed by residential facility for persons with chronic illnesses, an employee of the facility shall at least 4 hours of in-service training relate the care provided to such persons and in tactions necessary to control infections.	obtain ed to	D) STOTT OF THE THEILITY  WHE ALL . 2766(1).  D) DOMINISTRATOR WILL  MEDNITOR THEIL THE TO  ENGUEE NAC 149.2766  13 IN EON PH MEE WILL  HER PERCURTION.  C) DOMINICTED TOURS  MEDNITOR EMPLOYER				
	This Regulation is not met as evidenced to Based on record review, the facility failed to ensure six (6) of six (6) employees receive four (4) hours of training concerning the caresidents with chronic illnesses (Employee #2, #3, #4, #5 & #6).  Findings include:	to ed the are of	Coltection on consume STATE IS IN CONSUM WE THE WELL DESCRIPTION TALE COURSE SI SULL MINISTRATOR LICENSE VANGUEST DUE 7/31/0				
	•		Vancastor License				
	Employee #1 had an unknown date of hire There was no documented evidence of tra concerning the care of residents with chro illnesses.	aining	e) 7/31/09 8) employees #2,#3,#4				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIDENTIFICATION N		R/CLIA MBER	(X2) MULTIP A. BUILDING B. WING	•	(X3) DATE SU COMPLET		
		NVS5002AGC	Г <u></u>		TATE 719 0005	12/11	72008
NAME OF PE	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
HOLY FA	MILY ADULT CARE	HOME LLC		NEYPEAK A AS, NV 8910	8		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y1020	Continued From pa	age 57		Y1020	#5, 46 408 75		
	surveyor at the fac	ft with the administra illity. The administral all during the survey. ministrator.	or did not		3) NELLI ELLI BIVELD. Q) 7/31/09	<b>१८०५</b> ९.	402
	There was no emp The employee indi answer any question		could			,	
	Employee #3 had There was no emp	an unknown date of ployee file to review.	hire.				
	Employee #4 was employee file to re	hired on 9/2/08. The eview.	ere was no				
	Employee #5 was employee file to re	hired on 9/2/08. The eview.	ere was no				
	Employee #6 had There was no emp	an unknown date of ployee file to review.	hire.				
	Severity: 2 Scop	e: 3					
	I						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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